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President: Mr. Lykketoft (Denmark)

In the absence of the President, Mr. Gumende (Mozambique), Vice-President, took the Chair.

The meeting was called to order at 3.05 p.m.

Agenda item 11 (continued)

Implementation of the Declaration of Commitment on HIV/AIDS and the political declarations on HIV/AIDS

High-level meeting of the General Assembly on HIV/AIDS

The Acting President: I now give the floor to the representative of Estonia.

Mr. Jürgenson (Estonia): Estonia aligns itself with the statement delivered by the representative of the Netherlands on behalf of the European Union (see A/70/PV.99).

This high-level meeting is a unique opportunity to renew our political commitment to ending the HIV epidemic within the next 15 years. Estonia welcomes the important gains achieved in addressing the HIV and AIDS epidemic. At the same time, we acknowledge the remaining critical gaps and challenges. If we are to end AIDS by 2030, we must scale up the response through evidence-based policies and programmes and increased, adequate investments that address those gaps and challenges.

Estonia welcomes the outcome of the United Nations high-level meeting and its call for an accelerated response and renewed commitment. We thank the co-facilitators of this process, Ambassador Mwaba

Kasese-Bota of Zambia and Ambassador Jürg Lauber of Switzerland, for their able leadership in negotiating the document (resolution 70/266, annex). Estonia fully endorses a human-rights based and gender-responsive approach to fast-tracking the end of AIDS. We are committed to the effective implementation of the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development and the outcomes of their review conferences. In that context, Estonia also remains committed to sexual and reproductive health and rights.

We emphasize the need for universal access to quality and affordable comprehensive sexual and reproductive health information and education, including comprehensive sexuality education. Ensuring that no baby is born with HIV is an essential step towards achieving an AIDS-free generation. Providing prevention of mother-to-child transmission treatment to all women in need of it is the most effective way to eliminate new HIV infections among children and keep their mothers alive.

We commend the leadership role of the United Nations Children's Fund in setting the global agenda on prevention of mother-to-child transmission, as well as its efforts to scale up national prevention of mother-to-child transmission programmes in resource-limited settings. We must ensure that all babies, children, adolescents and their mothers are able to access life-saving HIV prevention, treatment, care and support. HIV/AIDS remains a major global public health issue. It also continues to pose a considerable health challenge for Estonia.

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By expanding testing at the primary care level, we are currently focused on ensuring that all people living with HIV know their status. Co-morbidities pose another challenge. The higher risk of contracting tuberculosis faced by people living with HIV is well known. Containing tuberculosis among people living with HIV and thereby avoiding a combined epidemic is of the utmost importance. This challenge can be overcome by paying greater attention to the need to make existing services more patient-oriented and promoting networking among different professions.

For a holistic patient-centred approach, we are currently offering combined services for HIV and tuberculosis as well as HIV and opioid substitution therapy. All HIV- and tuberculosis-related services, including harm reduction services, are fully funded by the State budget. While dealing with these challenges, we are constantly striving to find innovative solutions and promote the use of technology. In addition to the digital solutions already used within the national e-health system, we are currently seeking specific solutions that would address the challenges specific to HIV/AIDS.

HIV epidemics in different regions have different contexts. The European region is the only one in which the number of new infections is still growing. Injecting drug use still accounts for almost half of all new HIV cases in Eastern Europe and Central Asia. This epidemic cannot be stopped in this region without harm reduction and access to healthcare and social services. We call on the Joint United Nations Programme on HIV/AIDS to provide assistance to Member States in that regard.

In line with the 2030 Agenda for Sustainable Development (resolution 70/1), we support the need to strengthen health systems and capacities for broad public health measures and to promote well-being, and we commit to advancing universal health coverage and access to essential health services and medicines for the prevention and treatment of HIV and AIDS and related services. We must commit to improving our response and support for prevention, treatment and care among key populations at higher risk of HIV, including sex workers, people who inject drugs, men who have sex with men, transgender people and people in prison, among other groups at risk in different settings and geographical areas.

The Acting President: I now give the floor to the representative of Cameroon.

Mr. Tommo Monthe (Cameroon) (*spoke in French*): Cameroon welcomes the adoption of the Political Declaration on HIV/AIDS (resolution 70/266, annex) entitled "On the Fast Track to Accelerate the Fight Against HIV and to Ending the AIDS Epidemic by 2030". We associate ourselves with the statement made by the representative of Zambia on behalf of the Group of African States (see A/70/PV.98). We welcome the inclusion in the Declaration of the provision on national sovereignty, which is essential and which encourages national ownership and leadership by Governments in the fight against HIV and AIDS. That provision ensures that the provisions of the Declaration are implemented in strict compliance with each country's national laws, cultural and religious values and development priorities.

My delegation would like to take this opportunity to reiterate the African position with regard to the use of the term, key populations, the meaning of which will vary according to the national context and the local epidemiological context of each country. Cameroon is among the most affected countries, with a prevalence estimated at 4.3 per cent of the population of adults aged 15 to 49. It remains in a generalized epidemic, although the situation has stabilized, with a 20 per cent reduction between 2004 and 2011.

In order to eradicate the devastating effects of the epidemic, which slows development efforts, the Government of Cameroon includes the fight against HIV/AIDS among its national priorities, with the personal involvement of the President of the Republic, His Excellency Mr. Paul Biya and the important contribution of the First Lady, Mrs. Chantal Biya, whose network of associations and the African Synergies organization bring real added value to the national struggle against HIV and AIDS.

Owing to the combined efforts of the Government, development partners, the private sector and civil society, the implementation of various strategic plans developed since the launch of the Cameroonian response has yielded encouraging results in terms of expanding access to the necessary treatment, care and support for those infected and affected by HIV and AIDS; preventing mother-to-child transmission of the virus; and preventing new infections among the general population and high-risk groups. Cameroon's response is characterized by a strong political commitment, in

the form of an increase in national resources allocated to the fight against AIDS, from €1.525 million in 2002 to €15 million in 2015.

In order to halt the advance of the epidemic, reverse trends and mitigate the negative impact of AIDS on the general population, Cameroon is taking a series of actions to provide an analysis of the epidemic, assess its social and economic impacts and the needs in terms of the national response, including the cost of antiretroviral treatment. In a context characterized by a significant proportion of people who do not know their HIV status, Cameroon has decided to intensify prevention efforts. The key achievements in this part of the fight against HIV and AIDS are, first, communication and education aimed at bringing about behavioural change; secondly, strengthening screening campaigns and availability of and access to condoms, which have a special place in our struggle; thirdly, achieving transfusion safety, with the establishment of a national blood transfusion programme in 2013; and fourthly, preventing mother-to-child transmission, which remains one of the priority areas.

With regard to access to care and treatment, Government efforts are completely plausible. In its strategy for combating HIV/AIDS, Cameroon has also undertaken to provide enhanced support for and protection of people living with HIV, orphans and vulnerable children and people affected by HIV, in order to mitigate the psychological, social and economic impact that HIV has on them. Psychological support is being promoted, and efforts are being made to provide health, educational, nutritional, psychological support and legal protection to orphans and vulnerable children. Efforts are also being made to increase civil society and private sector involvement in the fight against AIDS.

Taking into account the strengths and weaknesses identified by the assessment of the national strategic plan and international approaches to the fight, particularly the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 target, the Government, with the support of its partners, has developed a three-year plan to accelerate therapy for 2015 to 2017, with ambitious targets related to the screening of pregnant women and children at risk. It has also adopted the test-and-treat strategy for the general population and a laboratory extension plan aimed at achieving viral load control.

I conclude by noting that the greatest challenge will be that of mobilizing the necessary funds in the midst

of a financial and economic crisis. We call upon the international community to continue to support such international financing mechanisms as the Global Fund to Fight AIDS, Tuberculosis and Malaria. We also call for the generosity shown through other mechanisms, such as the United States President's Emergency Plan for AIDS Relief, UNAIDS and the French Therapeutic Hospital Solidarity Network, to continue. Their invaluable support has been crucial in the fight against HIV/AIDS in Cameroon. My country is convinced that, with a strong political commitment and the increased involvement of all partners in making available the resources needed for the fight against HIV and AIDS, we can defeat this pandemic by 2030 or before then, by 2020 as set out in the Declaration.

The Acting President: I now give the floor to the representative of Mongolia.

Mr. Sukhee (Mongolia): It is my great honour and privilege to address this very distinguished audience on behalf of the Government of Mongolia. My Government highly commends the world for coming together as one in the fight to end the AIDS epidemic as a public health threat by 2030 and welcomes this important opportunity to assess the progress made towards realizing the 10 targets of the 2011 Political Declaration on HIV and AIDS. The Political Declaration has played a crucial role in scaling up the HIV response in my country. The following results should be underscored.

First, the Government of Mongolia is successfully fulfilling the commitment it made at the high-level meeting on HIV/AIDS in 2011, to ensure zero vertical transmission of HIV and zero new infections as a result of blood transfusion.

Secondly, life-saving antiretroviral treatment is provided free of charge to all people living with HIV.

Thirdly, measures have been taken to reduce the national AIDS response's dependence on shrinking donor support. As a result, allocations from the State budget for the AIDS response have almost doubled in the past five years, and the procurement of antiretroviral drugs is funded entirely by domestic resources.

Fourthly, legal reform is under way to end policies and practices that reinforce discrimination, particularly against people living with HIV and key populations. The law on prevention of HIV/AIDS was revised in December 2012, and HIV-related travel restrictions and other discriminatory provisions targeting people

living with HIV have been lifted. For the first time, the revised Criminal Code, which will enter into force in September, has criminalized discrimination and offences on the basis of sexual orientation and gender identity.

Mongolia has been successful in maintaining a low prevalence of HIV infection among the general population. However, in the recent past the number of reported cases has been growing exponentially, with more than half of all notified HIV cases being reported in the past five years. Modelled projections show that HIV prevalence in Mongolia could triple in the next five years without an expanded national AIDS response. There have been no substantial improvements in condom usage among adults and young people in the recent past. Young adult awareness of HIV infection and prevention is well below the global targets.

Coverage of HIV prevention programmes among key populations has fallen more than twice in the past five years due to the decline in donor support brought about by Mongolia's transition to upper middle-income country status. This clearly demonstrates that our achievements are very fragile, especially in countries like Mongolia, which have recently been promoted to middle-income status and in which a decrease in development assistance is likely to lead to a crisis in HIV funding. The space for domestic investment in the AIDS response in middle-income countries is further limited by the growing double burden of disease, as the prevalence of non-communicable diseases is rising more rapidly than that of infectious diseases, including HIV.

Although the Government of Mongolia has been gradually increasing domestic funding for the AIDS response, programmes focused on key populations still require more investment, as they are often run by civil society. In other words, it is the community-based programmes for key populations that suffer the most as a result of moving away from investing in the AIDS response in middle-income countries. Reflecting on this reality, Mongolia would like to ask the Joint United Nations Programme on HIV/AIDS and other international partners to focus not only on countries, but also on poor and vulnerable population groups within countries, including middle-income countries.

An estimated 70 per cent of HIV-positive people live in middle-income countries. Scaling back development assistance in those countries puts those in greatest need at risk and jeopardizes our collective

progress towards the global vision of zero new HIV infections, zero HIV-related deaths and zero HIV-related discrimination. Following the adoption of the 2030 Agenda for Sustainable Development (resolution 70/1), in which we committed to leaving no one behind, Mongolia's 2030 Sustainable Development Vision was launched last April.

In conclusion, I would like to reiterate my Government's strong commitment to accelerating the pace of progress made in fighting HIV/AIDS and other communicable diseases and epidemics and to the Political Declaration on HIV and AIDS (resolution 70/266, annex).

The Acting President: I now give the floor to the representative of Mauritius.

Mr. Koonjul (Mauritius): Mauritius welcomes this very important high-level event to address the HIV/AIDS epidemic. We also welcome the Political Declaration (resolution 70/266, annex) adopted on Wednesday as a testimony of our global commitment and renewed engagement to eradicate HIV/AIDS. The Secretary-General's report (A/70/811) on the fast track to ending the AIDS epidemic provides an assessment of our past actions, identifies gaps and challenges and makes recommendations for action-oriented approaches that will support our endeavour to end AIDS by 2030.

Despite the efforts made by all stakeholders, the Secretary-General's report notes that progress in reducing the number of infections worldwide has been slow and uneven. In some areas, new infections have actually been rising, and awareness of HIV transmission and comprehensive knowledge about the disease has been stagnating. As policymakers, we must pursue our advocacy efforts and ensure that health care and related services are provided. We need to strengthen preventive measures aimed at the key affected populations, and we must always ensure that our words are matched by our deeds by providing a comprehensive package of treatment, prevention and support to all those affected.

Mauritius has a concentrated epidemic, with an HIV prevalence of 0.8 per cent among the general population. The prevalence of HIV is above five in each of the key affected populations. The most affected people are those who inject drugs, at about 43 per cent; non-heterosexuals, at 20 per cent; prison inmates, at about 20 per cent; and less than 1 per cent among pregnant women. Well aware of the impact of HIV/AIDS on people, communities and the country, Mauritius has

taken strong measures to address the epidemic. We have remained attentive to and rigidly followed international guidance on the subject of HIV programming and on the monitoring and evaluation of the programme set by such international organizations as the World Health Organization, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime.

Mauritius is committed to implementing the Sustainable Development Goals and the fast-track approach to end the AIDS epidemic by 2030. Our 2016-2021 national HIV action plan drives the 90-90-90 targets and is aligned with the UNAIDS 2016-2021 Strategy. By the end of 2020, Mauritius is projecting that it will have diagnosed 90 per cent of all people living with HIV, started and retained 90 per cent of those diagnosed with HIV on antiretroviral therapy and achieved real viral suppression for 90 per cent of patients on antiretroviral therapy, keeping in spirit the vision of the three zeroes: zero new infections, zero discrimination and zero AIDS-related deaths.

Our Equal Opportunity Act of 2008, the HIV and AIDS Act of 2006 and the Protection of Human Rights Act of 1998 provide the legal frameworks that help to facilitate the expansion of programmes on HIV and AIDS prevention and management among all levels of the work force. Those policies and frameworks also consolidate the actions taken to eliminate stigma and discrimination. We are actively engaged in creating community awareness and programmes targeting the key affected populations. Special activities aimed at the youth have been set up in order to impress upon them the need to avoid dangerous sexual practices, use of intravenous and all other drugs and unsafe piercings and to follow good hygiene practices, including getting tested and knowing their HIV status.

We also have a very successful programme on the prevention of mother-to-child transmission, which has kept the prevalence of HIV among pregnant women at under 1 per cent. Mauritius is aiming to become the first country in the region to completely eliminate mother-to-child transmission of HIV. More importantly, we continue to involve all stakeholders — including civil society and non-governmental organizations — in this exercise.

In March, the Government of Mauritius opened a new medical facility in the women's detention centre. Medical care for detainees is in keeping with human

dignity and contributes significantly to the health status of the communities to which prisoners belong. Our aim is to ensure that incarcerated people lead a healthy lifestyle, bearing in mind that they will return to their families and communities eventually. We are doing everything within our capacity to provide the best health care possible to our people.

The Government is the major source of HIV and AIDS funding, accounting for 72 per cent of all spending, while 26 per cent of the national response comes from external sources, mostly the Global Fund to Fight AIDS, Tuberculosis and Malaria. Mauritius has benefited from a grant of about 8 million Euros from the Global Fund for the period 2010-2014 and is expecting another grant of 5 million under the Global Fund's new funding model for 2015-2019.

We would like to take this opportunity to make a special plea for contributions to the Global Fund and for enhanced collaboration from our partners, without which we will not be able to eradicate the HIV/AIDS epidemic. The Sustainable Development Goals will be significant and can be realized only if we take measures to safeguard the health of our people, who are not only the recipients of prosperity of a country, but are the very foundation, the contributors and the drivers of economic growth through their work, creativity and entrepreneurship.

The Acting President: I now give the floor to the representative of Australia.

Ms. Appleyard (Australia): This meeting is a major milestone in our joint efforts to halt the truly global AIDS epidemic.

Australia is pleased to align itself with the statement delivered on Wednesday by representative of Argentina (see A/70/PV.97) on behalf of many Member States, including Australia.

This week, we have taken an important step forward from the 2011 Political Declaration on HIV and AIDS, advancing our shared commitment to ending AIDS. The Declaration places a human rights approach to ending AIDS at its core. It recognizes the need to empower all women and girls, including their sexual and reproductive health and reproductive rights, and ensuring access to services for all key populations, as central to ending AIDS.

Australia would have liked this year's Political Declaration on HIV and AIDS (resolution 70/256,

annex) to have gone further, particularly on language relating to key affected populations. The 2016 Political Declaration outlines the minimum needed to end the AIDS epidemic. If we are truly to end this insidious epidemic, we need to do more. We will need to focus our attention upon key populations and implement evidence-based programmes that target those groups. We already know that this approach works — Australia's low rates of HIV transmission prove that it works.

In 2011, we all agreed to intensify our efforts to eliminate HIV and AIDS. We set 10 targets to be achieved by 2015, and together we have achieved or made significant progress towards achieving many of these targets. Australia is proud of its contribution to that effort. We have a long and consistent history of supporting the fight against HIV in our region, the Asia-Pacific region. Over the past decade, the Australian aid programme has provided over 1 billion Australian dollars to support HIV-specific programmes in our region, and we have seen some major achievements.

Since 1992, Australia has supported HIV programmes in Papua New Guinea, in line with that Government's national HIV and AIDS strategy. Last year, Australia assisted in providing HIV testing for 115,000 people, including 22,000 pregnant women. Domestically, Australia's seventh national HIV strategy explicitly recognizes key affected populations as people living with HIV, gay men and men who have sex with men, Aboriginal and Torres Strait Islander people, people from high HIV prevalence countries and their partners, travellers and mobile workers, sex workers, people who inject drugs and people in custodial settings. Transgender people are an additional important key population, as acknowledged in the Declaration.

Through our partnership approach with affected communities, Australia continues to have extremely low rates of transmission. For example, transmission among female sex workers and mother-to-child transmission are virtually non-existent. The early introduction of needle and syringe exchange programmes in the community and the efforts made by people who inject drugs to prevent transmission have kept HIV rates low in people who inject drugs. Australia is committed to the critical role of innovation and research in an effective response to HIV, including the importance of providing a vaccine and cure. Australia is a strong supporter of the international community's fight against HIV/AIDS. That is why we were proud to have hosted the twentieth International AIDS Conference in 2014.

We are pleased to see that over the past 10 years, domestic funding for AIDS has increased, accounting for 57 per cent of all AIDS funding in low- and middle-income countries in 2014. This is a critical step in integrating HIV programmes into nations' own health systems. Evidence-based, responsive public health systems are key to ending not only this epidemic, but also preventing future epidemics. However, we know that there is still a long road ahead. Globally, progress has been slower than expected in some areas, including vulnerable populations, legal frameworks, and gender equality. This is thwarting our ability to reach those most at risk of contracting HIV. We know that in our region, the Asia-Pacific, this epidemic strikes hardest at the people who are most often the victims of discrimination.

Australia supports the right of everyone to access the highest attainable standard of physical and mental health. We support universal health care and equal access to health services. For people living with HIV and those at risk, this encompasses universal access to HIV prevention, testing and treatment services without stigma or discrimination. This is vital to the success of public health services and fundamental to our human-rights approach to health. It is also the right and decent thing to do.

We must also ensure meaningful cooperation between healthcare professionals, policy makers, researchers, civil society and those affected and at risk, and we must all be held to account. We can only end this epidemic through understanding, respect and partnership — not by discrimination, stigma and criminalization. Let us now use the momentum of the 2030 Agenda for Sustainable Development (resolution 70/1) and this high-level meeting to galvanize all efforts — of Governments, international organizations, civil society and affected communities — to end AIDS by 2030.

The Acting President: I now give the floor to the representative of Sri Lanka.

Mr. Khan (Sri Lanka): First and foremost, the delegation of Sri Lanka would like to express its sincere appreciation to you, Mr. President, for chairing this high-level meeting on an issue that matters to all humanity. We would also like to express our gratitude to the Joint United Nations Programme on HIV/AIDS (UNAIDS) for their contribution to making this high-level meeting a reality. The human immunodeficiency virus, or HIV,

and AIDS epidemic has already devastated many individuals, families, and communities.

The epidemic has left millions of children orphaned, disrupted village and community life, and increasingly contributes to the erosion of civil order and economic growth. According to the World Health Organization and UNAIDS, an estimated 36.9 million people worldwide are living with HIV/AIDS today. Although one can find solace in the fact that the spread of this epidemic is gradually weakening, it is very far from being eliminated. This meeting is therefore timely. We are also delighted to see the successful conclusion of negotiations on the 2016 Political Declaration on HIV and AIDS (resolution 70/266, annex) and its adoption last Wednesday.

At present, Sri Lanka is classified as a country with a low prevalence of HIV infection. Since 1987, a cumulative total of 2,309 cases of people with HIV were reported in Sri Lanka, through the end of 2015. However, with 235 cases being reported in Sri Lanka in 2015, we are on high alert and have enhanced our efforts to obtain more accurate information on the situation. During the first quarter of 2016, 68 new cases of HIV were reported. We believe that this caseload accounts for only a fraction of the HIV-infected people in the country. We also note with concern that the proportion of HIV transmission due to male-to-male sex is gradually increasing and accounts for the highest number of reported cases among risk groups, which also include sex workers, sex clients, and drug users.

The national HIV/AIDS control programme, which falls under the umbrella of the Ministry of Health, provides both preventive and curative services. The national strategic plan for 2013-2017 directs the national response to HIV/AIDS. The Government hospital network in Sri Lanka provides HIV testing services through blood sampling, which is a component of their outreach services, as well as antiretroviral therapy. There are 14 antiretroviral therapy centres across Sri Lanka. In addition to antiretroviral therapy, HIV cases are handled by HIV care centres, which also provide counseling, support for disclosure and partner notification and screening for non-communicable diseases, among others.

Our delegation also concurs with the statements made by previous delegations underlining the importance of prevention as well as treatment of HIV/AIDS. The countries that have achieved demonstrable

success in prevention of HIV/AIDS have aggressive national intervention programmes that include such key components as behavior change communication, treatment of sexually transmitted diseases, increased access to condoms and increased access to HIV testing. Mass media, outreach, counselling and peer education have been used successfully to increase awareness and life skills among young people, persons engaging in high-risk behaviours and the public at large. Therefore, we can all learn much from these countries.

With regard to treatment, our delegation would like to underline the importance of making HIV/AIDS medicines, including generics, more affordable and of scaling up access to affordable HIV treatment. We note with concern that regulations, policies and practices, including those that limit legitimate trade in generic medicines, have seriously limited access to affordable HIV treatment in low- and middle-income countries like Sri Lanka.

In conclusion, I would like to state that Sri Lanka fully supports the 2016 Political Declaration and that it does its utmost to fight the spread of HIV/AIDS and offer whatever support it can give to eradicate the menace of HIV/AIDS from our world.

The Acting President: I now give the floor to the representative of Maldives.

Mr. Sareer (Maldives): Just last September, the international community agreed to accelerate the pace of progress made in fighting HIV/AIDS in an effort to end the epidemic by 2030. Today, we are gathered here to reaffirm our collective commitment to complete the eradication of HIV/AIDS. The Republic of Maldives applauds the international community for its steadfast dedication to this cause and fully supports the Political Declaration on HIV and AIDS (resolution 70/266, annex) entitled "On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030".

My delegation commends the Secretary-General for convening this meeting and for his report (A/70/811), which outlines the importance of the implementation of the Sustainable Development Goals in our quest to eradicate HIV/AIDS. The report also outlines the need for regional approaches in fast-tracking our response to HIV/AIDS, given the different epidemic patterns of the disease. The international community's collective efforts to address the AIDS epidemic have yielded significant results, including fewer new HIV infections

and AIDS-related deaths. Continued efforts in the areas of poverty reduction, maternal and child health and gender equality will undoubtedly enable us to go farther. Nevertheless, AIDS remains a public health and development challenge.

Under the Sustainable Development Goals adopted last year, the world has unanimously committed to ending the AIDS epidemic by 2030. Upholding this commitment requires urgent and steadfast action, as well as continued investments. The high-level meeting comes at a point at which it is crucial to advance the AIDS response in a way that also makes it possible to achieve the Sustainable Development Goals. The Government of Maldives has always attached great importance to mobilizing the national response to HIV and AIDS, which it continues to treat as a major public health concern. While HIV and AIDS in Maldives is categorized as low prevalence, research shows that there is high vulnerability and risks and that the country has a high epidemic potential.

Up until 2015, 23 cases of HIV-positive persons were reported in Maldives, 12 of whom have died of AIDS. Currently, there are nine persons living with HIV, and they are all on antiretroviral treatment. Maldives has a test-and-treat policy on treatment initiation, and the Government provides lifelong care and treatment. Although the prevalence rate of HIV/AIDS in Maldives is below 1 per cent, emerging trends have increased the locals' risk of exposure to a wide range of infectious diseases, including HIV/AIDS and other sexually transmitted infections. Moreover, injecting drug use and associated high-risk sexual behaviors remain the most likely triggers for an HIV epidemic in the Maldives. As such, Maldives supports HIV prevention strategies targeting drug users, among other key populations.

Maldives is committed to working diligently to maintain the low prevalence of HIV in the country. The national AIDS programme, which operates under the Health Protection Agency of the Ministry of Health, coordinates efforts to prevent and control HIV and AIDS. Maldives has a multisectoral national strategic plan on HIV and AIDS, effective from 2014 to 2018, with three major objectives: first, to strengthen essential services targeting key affected populations; secondly, to improve prevention efforts for the general population and special groups, including youths and migrants; and thirdly, to reduce the stigma and discrimination surrounding HIV and AIDS.

The national strategic plan also provides a framework for achieving three underlying strategic directions. These directions highlight the need to strengthen HIV prevention, care, treatment and support services, the need to improve strategic information systems for HIV programmes and research and the importance of creating an enabling environment. Despite the measures taken by the Government to prevent and control the spread of HIV and AIDS, Maldives' attempt to carry out effective and efficient targeted programmes and interventions is confronted with many constraints.

The geographical distribution of Maldives makes the implementation and delivery of those services extremely expensive, with transportation between atolls using up the bulk of funding. Following Maldives' graduation from the least developed country list, accessing such funding systems as the Global Fund to Fight AIDS, Tuberculosis and Malaria has been a challenge, as has been the case with gaining preferential access. Arbitrary classifications based on income levels unfairly disadvantage those with genuine needs. In addition, civil society partners in this field are limited, and their ability to target key affected populations is limited in turn.

We are hopeful that the renewal of our commitment at this high-level event will bring about changes by promoting inclusiveness through a differentiated approach that will allow such countries as Maldives to tap into the funding and technical expertise required to fight HIV and AIDS. My delegation looks forward to working with all Member States as we take on the fight to eliminate HIV/AIDS by 2030. We call upon all involved to support one another's efforts to deliver favorable outcomes for the noble cause.

The Acting President: I now give the floor to the representative of Canada.

Mr. Grant (Canada) (*spoke in French*): Canada joins the consensus and endorses the Political Declaration on HIV and AIDS (resolution 70/266, annex), but let us be clear — we must go further. It is Canada's intention to do so. For us, the successful implementation of the Political Declaration rests on three key elements: first, we must expedite access to HIV prevention, screening and treatment services in countries that have a high prevalence. Too many people are either unaware that they are infected or do not yet have access to treatment.

(spoke in English)

That is why Canada, along with many other countries, has endorsed the Joint United Nations Programme on HIV/AIDS fast-track initiative, which calls for ambitious treatment targets to be achieved by 2020. Secondly, we must prioritize the needs of key and vulnerable populations, in particular. We need comprehensive, evidence-based prevention programmes and services to reduce new HIV infections among key populations. We also need to engage them in the implementation process, especially at the local level. Young women and girls are also particularly vulnerable to HIV transmission.

In high-burden countries like South Africa and Nigeria, girls account for more than 80 percent of all new HIV infections among adolescents. This cannot go on. We need to work with all partners to reach women and girls with comprehensive sexual and reproductive health services and education, take meaningful steps to prevent and end domestic violence and abuse, and involve boys and men. It is also very important to recognize the vulnerability of indigenous populations around the world. Their needs are often unique and must be addressed.

Canada also recognizes and protects the legal rights of the lesbian, gay, bisexual, transgender and queer community to live free from discrimination, hate propaganda and hate crimes. Similarly, Canada's approach to injection drug use at home and globally includes prevention, compassionate treatment and evidence-based harm reduction approaches. In these efforts, we must ensure the active engagement and participation of civil society, local governments and their communities.

We must also innovate now and over the long-term to make treatment cheaper and more effective and to find a cure for HIV. This means investing in research and development in science and new technologies to decrease costs and increase access to treatment not just for AIDS, but also for tuberculosis and malaria, the two main causes of death for people living with AIDS. I would like to acknowledge the Bill and Melinda Gates Foundation for their extraordinary contributions in this area. The Global Fund to Fight AIDS, Tuberculosis and Malaria is another excellent example of innovation. I would like to commend the Global Fund implementing countries for investing in strengthening their health

systems, improving governance and reducing the rate of disease.

I also want to recognize the Global Fund's leading private-sector contributor, RED, which has raised over \$350 million for AIDS programmes in Africa from the sale of RED-branded products and services through iconic world brands like Apple, Coca-Cola and Starbucks. Canada recently announced a 20 per cent increase to its Global Fund contribution to \$780 million for 2017 to 2019. We are also proud to host the Global Fund Replenishment Conference this coming September. I invite all present to support this effort and look forward to seeing many of them in Montreal for the replenishment. This will be a big year for the fight against HIV/AIDS. Canada will be there and will do our part to implement the Political Declaration and to do even more to end the HIV/AIDS epidemic for good.

The Acting President: I now give the floor to the representative of Guatemala.

Mr. Sandoval (Guatemala) (*spoke in Spanish*): I am delivering this statement on behalf of my country's Minister of Public Health and Social Assistance, Mr. José Alfonso Cabrera Escobar. I hereby convey his respectful greetings and acknowledge our participation at this gathering.

Fifteen years after we, the countries represented here, committed to fighting the HIV/AIDS epidemic, we are on the verge of making what was then a dream a reality by putting an end to this epidemic as a public health problem by 2030. In order to achieve that goal, each of our countries must redouble its efforts and actions, because we must not grow weary. Our Government attaches priority to the recognition and exercise of the human rights of persons with HIV/AIDS, key populations and diverse communities, which continue to be discriminated against by some sectors of society — a state of affairs that other representatives have also recognized as an obstacle that must be overcome. Like many other countries, we are working to eliminate the legal barriers that limit access to treatment. Based on joint efforts with civil society organizations, we have reordered actions taken to meet the targets of the 90-90-90 strategy.

We have one problem — resources are scarce. As a result, they are rationed and target key at-risk populations. However, as earlier speakers have said, this is not a task for a single Government; it is a joint effort that will require the contributions of all sectors,

as it is only by collective effort that we will achieve the ultimate goal of reaching the target of zero deaths from HIV/AIDS, zero infections and zero discrimination.

Guatemala is currently going through a special period of combating corruption and purging Government entities that had been co-opted by previous leaders, who have now been detained and duly prosecuted. This is a key moment in the country's history, because it has allowed us to get back on the course that, at one point, had also had an impact on the fight against HIV and AIDS.

We cannot conclude without acknowledging the support that the Joint United Nations Programme on HIV/AIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria have provided to Guatemala, because their contributions have been and will remain central to the road that we have yet to travel as a country. Joining forces and supporting one another, we will be able to overcome all the barriers that prevent future generations from inheriting a better world, in which HIV/AIDS will be nothing more than an artefact that we succeeded in eradicating.

The Acting President: I now give the floor to the representative of Finland.

Mr. Laaksonen (Finland): It is an honour and pleasure to address this high-level meeting. This is a key moment in the global AIDS response. After more than three decades of efforts working against AIDS, we have a unique opportunity to fast-track the end of the AIDS epidemic as a public health threat by 2030 and to transform and advance global health, in line with the 2030 Agenda for Sustainable Development (resolution 70/1). Ensuring the success of the Sustainable Development Goals, including ending AIDS, requires universal responsibility and a coherent approach to make sure that no one is left behind. In order to do so, our focus must remain strong.

Finland fully endorses a human rights-based and gender-responsive approach, taking into account the needs and rights of the people most affected by the epidemic and at a higher risk of infection. We need an inclusive response that is strongly committed to the full realization of all human rights and fundamental freedoms, dignity and social justice. Addressing the epidemic among young women and adolescent girls, children, young men, migrants and key populations, including men who have sex with men, people who inject drugs, sex workers, transgender people and prisoners, is

an essential element in the global response. By ensuring equal access to high-quality combination prevention, testing and treatment, free from discrimination and stigma, we can take an enormous step closer to ending the epidemic. In addition to being rights-based, this approach is cost-effective and has been proven to work.

If the people most affected and most discriminated against are left behind, we run the risk of jeopardizing the effort to end the AIDS epidemic by 2030. In particular, adolescent girls and young women are currently being left behind and denied their full rights. Therefore, it is fundamental to reaffirm the need for greater attention, commitment and action to ensure that all women and girls have the rights and knowledge needed to make decisions concerning their own body, sexuality and reproductive health. Such empowerment is crucial in order for all women and girls to be able to lead healthy lives and participate actively in society. We must invest in gender-transformative HIV programmes that also engage boys and men. Doing so is particularly important when working with issues relating to sexual and reproductive health and rights.

Another element of effective prevention is quality comprehensive sexuality education, which empowers young people by providing the information and tools they need to make safe, healthy and educated decisions about their sexual and reproductive lives. Comprehensive sexuality education is also important in advancing tolerance, mutual respect and non-violence in relationships. Universal health coverage can be effectively provided only by a resilient health system. Our experience is that access to comprehensive HIV and AIDS services incorporating prevention, treatment, care and support for all promote a sustainable HIV response and a strong national health system.

Going forward, greater investment in advocacy, civil society and community-based services is essential for fast-tracking the HIV response. We must also look closely at the interlinkages between different sectors and work through partnerships that embrace relevant stakeholders. In a world of diverse and interlinked challenges, we need to share responsibility and together contribute to ending AIDS by 2030.

The Acting President: I call on the observer of the Observer State of the Holy See.

Monsignor Auza (Holy See): After years of shocking narratives on the loss of health and life among men, women and children living with HIV, my

delegation is pleased with the progress detailed in the Secretary-General's report (A/70/811) entitled "On the fast track to ending the AIDS epidemic". It is indeed heartening to set strategic goals and benchmarks with a view to ending this disease and to do so within the more comprehensive framework of the 2030 Agenda for Sustainable Development (resolution 70/1). However, my delegation urges the international community to pay equal attention to the cautionary note raised in the report, namely, that AIDS is far from over despite remarkable progress and that if we accept the status quo unchanged, the epidemic will rebound in several low- and middle-income countries.

In that regard, Catholic-inspired organizations often report the persistent obstacles posed by the lack of access to early diagnosis and treatment; by the lack of appropriate, affordable, and accessible child-friendly formulations and dosages of medications for paediatric use; by changes in funding priorities imposed by donor Governments and agencies, resulting in disruptions of services for those who do not live in the so-called HIV hotspots; by frequent stock-outs of medicines and diagnostic equipment and supplies; and by interruptions of treatment, especially of women and young people who are subjected to stigma, discrimination and physical and emotional abuse as a result of their HIV status.

While global goals and targets will essentially be moving forward, they must be anchored in reality, integrating the very real concerns that respective countries have in considering the holistic well-being of their people. Discrimination and stigmatization can never be an excuse to exclude or leave anyone behind. Every effort must be made to distinguish between policies that discriminate and stigmatize and those that are put in place to discourage risk-taking behaviours and encourage responsible and healthy relationships, especially among the youth.

While access to prevention, treatment and health care services must be guaranteed to all, they will never be enough by themselves to end HIV transmission and AIDS. We must continue to address the root causes and promote healthy lifestyles. The obstacles to eradicating the spread of HIV/AIDS give ample evidence of the fact that in different parts of the world, especially in many regions of Africa, health care is still a privilege of the few who can afford it. As Pope Francis has said, access to health care, treatment and medicine remains a dream for too many. Health-related issues, such as HIV/AIDS and related infections, require urgent political

attention, above and beyond all other commercial or political interests.

Presently, as many as 50 per cent of HIV-positive children die before their second birthday because they do not have access to the necessary diagnosis, treatment and medication. In fact, the majority of HIV-positive children are not diagnosed until they are four years of age. Taking up those concerns, the Holy See recently convened two meetings in the Vatican with the executive-level leaders of companies that manufacture pharmaceuticals and diagnostic equipment, in order to plan a more timely and appropriate response to children living with HIV and tuberculosis.

These business leaders, together with representatives of specialized multilateral organizations, Governments, religious and other non-governmental organizations, agreed that providing affordable, appropriate and accessible HIV medicines and diagnostic tools for paediatric use everywhere is an urgent global goal, thus committing themselves to overcoming the obstacles and accelerating access to diagnosis, treatment and medication for children living with HIV/AIDS. The Holy See and all the institutions of the Catholic Church are more motivated than ever to consider the plight of children living with HIV. Together, let us muster the will, continue to sharpen the technical expertise already available and find the resources necessary to provide access to diagnosis, care and treatment, not only for a privileged few, but for all.

The Acting President: In accordance with resolution 49/2 of 19 October 1994, I call on the observer of the International Federation of Red Cross and Red Crescent Societies.

Mr. Senghore (International Federation of Red Cross and Red Crescent Societies): As we gather this week with the common goal of addressing the HIV/AIDS agenda and the 2030 Agenda for Sustainable Development (resolution 70/1) has been adopted, it is hard not to look back on the past decades and think about the devastation that HIV/AIDS has wrought upon the people who have contracted the virus, as well as the on children who have lost their parents, the spouses and families who have cared for them and all those who have lost their families as well.

Yet we should also acknowledge that the fight against HIV/AIDS gave birth to a global solidarity movement without which we would not have come this far. None of this was easy — and the creation of that movement was

not always smooth — but none of the successes could have been achieved without the understanding that this disease affected us all. Without the concerted efforts of all involved, we would not be here today. On behalf of the International Federation, I am glad to commend Member States for adopting the Political Declaration on HIV and AIDS (resolution 70/266, annex), which will move us forward to implementing the 2030 Agenda. Nonetheless, these successes require concerted efforts, not only from Governments but also from such institutions as civil society, non-governmental and international organizations.

As we pointed out as early as 2011, our efforts in reaching out to key populations are still much too limited, and stigma, discrimination and violations of human rights are still rampant in far too many places. Concrete commitments are needed to remove all barriers to access to comprehensive HIV/AIDS services for each key population group. In order to reduce transmission of HIV among people who inject drugs, we need human, evidence-based harm reduction policies and a recognition that much more must be done to reduce stigma and discrimination against them.

In developing countries, concerted efforts must be directed towards the strengthening of community health systems, particularly in rural settings and remote areas, where the health system and other basic infrastructure are scarce or non-existent. In so doing, we will also build far more resilient communities, not just for addressing HIV and other health risks, but for providing responses to all other shocks and stresses.

And for those who are caught in the middle of emergencies, we really need to look at how HIV/AIDS programming can reach them. As the Assembly knows, 1 out of every 19 persons living with HIV/AIDS comes from disaster contexts. We must do a much better job of ensuring that these people are not victimized, either by becoming infected, through human trafficking or gender- and sexual-based violence, or through the lack of access to life-saving drugs.

The International Federation of Red Cross and Red Crescent Societies, acting through its 190 national societies and 17 million volunteers, has been mobilized in support of Government and community efforts to address this epidemic and will continue to be so as we cover the last mile. On an annual basis, our HIV programmes empower 20 million people throughout the world, including 16 million through information,

education and communication programmes, 3 million among the most at-risk populations, which in turn includes 20,000 drug users and 100,000 persons living with HIV/AIDS. Every year, we also train and engage 100,000 volunteers to reach out to their communities through prevention, care and support. And wherever they go, they will take that knowledge and commitment with them.

As we look ahead to the next 10 years, our volunteers and national societies will stay the course. But most importantly, they will be part of a great global solidarity movement that is striving to end AIDS by 2030.

The Acting President: In accordance with resolution 57/32, of 19 November 2002, I give the floor to the observer for the Inter-Parliamentary Union.

Ms. Torsney (Inter-Parliamentary Union): Parliaments and parliamentarians have very important responsibilities in reaching the 90-90-90 goals and ending AIDS by 2030. As legislators, overseers of Government action and opinion leaders, members of parliament are well placed to help strengthen prevention measures and expand access to HIV treatment.

Earlier this week, the Inter-Parliamentary Union (IPU) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) organized a side event for parliamentarians attending this high-level meeting. Members of parliament from five continents identified key actions for parliaments to fast-track and end AIDS. National engagement is key. Parliamentarians must understand the epidemic and who are their most vulnerable groups to ensure effective parliamentary action. As representatives of the people, parliamentarians are the critical link between national strategies, communities and individuals from different walks of life. Parliamentarians' primary objective should be to make a difference in the lives of their constituents and particularly those affected by HIV.

In our meeting, many parliamentary colleagues shared examples of bold action they had taken to address the needs of vulnerable populations through legislation and programming. They noted with regret, however, that 35 years into the AIDS epidemic, subjective impressions still prevail over facts and evidence, hindering progress with less effective programmes and limited action. In too many places, stigma and legal discrimination persist as an immense barrier to voluntary testing and treatment. As opinion leaders, parliamentarians can

play a key role enlightening people, fighting HIV-related stigma and discrimination at the national level and within their local constituencies. Members of parliament can be national role models.

Several participating parliamentarians expressed concern at the overreliance on donor funding for the AIDS response, which is fast depleting in countries graduating to middle-income levels. They recommended that the political commitment to ending AIDS be translated to stronger domestic financing of programmes. They called for capacity-building and support to parliaments to ensure a sustainable, well-funded AIDS response.

The 2030 Agenda for Sustainable Development acknowledges the

“essential role of national parliaments through their enactment of legislation and adoption of budgets and their role in ensuring accountability for the effective implementation of [Government] commitments” (*resolution 70/1, para. 45*).

Goal 16 explicitly emphasizes the importance of effective institutions, including parliaments, in implementing all the Sustainable Development Goals through coherent policies that capture and build on synergies. This is the main entry point for the IPU and national parliaments to engage with this new development framework.

At this high-level meeting, the General Assembly has adopted a Political Declaration on HIV and AIDS (resolution 70/266, annex) that sets a bold new vision of a world free of AIDS. The IPU and its members are particularly pleased to see strong references to rights and inequalities throughout the document as well as the importance of effective laws and policies. The world will not meet these noble goals unless parliamentarians and parliaments are engaged. The Declaration recognizes the strong role the IPU has played in the AIDS response and we look forward to providing continued contribution.

Parliamentarians effectively engaged in the AIDS response, can and do provide critical leadership in realizing a new vision for health that leaves no one behind. Members of parliament attending the high-level meeting urged the IPU and the Joint United Nations Programme on HIV/AIDS to work with parliamentarians everywhere to implement the commitments of the 2016 Political Declaration, and they pledged to continue providing peer to peer support

for their colleagues in other parliaments. The IPU and UNAIDS have developed tools and handbooks to support parliamentarians engaged in this work. The IPU stands ready to continue the fight to end AIDS.

The Acting President: In accordance with resolution 477 (V), of 1 November 1950, I give the floor to the observer of the League of Arab States.

Mr. Fathalla (League of Arab States) (*spoke in Arabic*): Allow me at the outset to express to the General Assembly our thanks and appreciation for convening this high-level meeting on HIV/AIDS. We also thank the Secretariat for inviting the League of Arab States to participate in this important meeting.

In March 2014, the Council of Arab Health Ministers unanimously adopted a Arab strategy in order to respond to HIV/AIDS for the period from 2014 to 2020, with a view to bringing forth in the Arab States a generation free of AIDS. The strategy was adopted after two years of constant work and consultation with all States members of the Arab League, and with the much-appreciated technical support of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and specialized United Nations agencies, as well as support from civil society.

The 10 goals in the strategy are as follows: first, reducing the rate of infection by transmission through sex by 50 per cent by 2020; second, reducing the rate of infection as the result of intravenous drug use by more than 50 per cent by 2020; third, eradicating HIV/AIDS among children and reducing maternal mortality rates; fourth, accelerating efforts made to implement antiretroviral therapy consistent with the new guidelines set by the World Health Organization and working to enable more than 80 per cent of those who qualify for full treatment in the Arab States to receive it; fifth, reducing by more than 50 per cent by 2020 the mortality rate of those living with HIV who die as a result of tuberculosis; sixth, providing special resources to respond to AIDS and increasing national spending on AIDS by more than 80 per cent by 2020 in all Arab countries; seventh, achieving gender equality in terms of access to services, eliminating gender-based violence and empowering women and girls to protect themselves from HIV/AIDS infection; eighth, fighting stigmatization and discrimination of those living with HIV/AIDS and others who are affected by the disease by enacting, revising and modernizing laws and policies that would ensure the full implementation

of all human rights and fundamental freedoms; ninth, providing prevention, treatment, support and care for key populations, including mobile populations, by focusing on displaced persons, refugees and migrant workers; and tenth, strengthening and mainstreaming the AIDS response in all health and development and social protection efforts.

The Arab strategy to fight AIDS is a timely measure that will create great opportunities as we mobilize new technologies, knowledge, methods and synergies designed to achieve zero new infections, zero discrimination and zero mortality in relation to AIDS. The strategy takes into consideration the diversity of the countries and the patterns and other features of the epidemic, including the epidemiological, social, political and legal aspects, as we jointly seek to find approaches that could be adapted to the Arab context while ensuring the implementation of the full rights of those living with the disease and other key populations. This is being done by providing protection, treatment, care and support for all infected people, while emphasizing the multisectoral approach involving health, education, work, finance, youth, mass media and civil society. The strategy also seeks to expand and encourage the programmes and activities that contribute to mainstreaming AIDS services in development and health programmes.

The Arab States have shown strong political will by accepting regional and global commitments, and, in the past few years, we have undertaken a number of strategic regional initiatives. First, Arab Parliaments agreed to an Arab Treaty on the Rights of People Living with HIV/AIDS in order to protect society by respecting human rights and fundamental freedoms and permitting people to live in dignity. Secondly, the regional initiative designed to eradicate new infections in children and to support women's right to living healthy lives, which was launched in October 2012 by the World Health Organization, UNICEF, the United Nations Population Fund and UNAIDS, is yet another concrete step towards achieving zero new infections in children. Thirdly, the initiative to accelerate treatment in the East Mediterranean region, which was developed by the World Health Organization and UNAIDS, was adopted by the Regional Committee of the World Health Organization in October 2013 in the Sultanate of Oman in order to expand coverage and ensure universal access to treatment and testing services in the region.

The Council of Arab Health Ministers has adopted specific recommendations from Member States for implementing and following up on the Arab strategy for fighting AIDS. First, national policies, strategies and plans in the fight against HIV/AIDS are to be reviewed and modernized to ensure that they are aligned with the Arab strategy to fight AIDS and that they include different options and guarantee respect for human rights. Secondly, the political commitment to ensuring universal access to prevention, treatment, support and care services for people living with HIV/AIDS is to be strengthened. Thirdly, increased human and financial resources are to be allocated, with a view to ensuring the implementation of national priorities consistent with national and regional strategies. Fourthly, legal, administrative and other effective measures are to be developed to help strengthen the AIDS response. Fifthly, interventions to prevent exposure to HIV/AIDS are to be strengthened. Sixthly and lastly, the systems for collecting and analysing information on the spread of HIV/AIDS are to be bolstered and their progress monitored.

In conclusion, I would like to refer to the ministerial decision taken by the League of Arab States Ministers of Health in March 2016 urging all Arab countries to intensify and streamline their efforts to end AIDS by 2030. I would like to express our appreciation for the leadership and technical support that has been provided by UNAIDS in support of the Arab strategy to fight AIDS. We all look forward to the end of AIDS by 2030 within the context of the 2030 Agenda for Sustainable Development (resolution 70/1).

The Acting President: In accordance with resolution 57/29, of 19 November 2002, I now give the floor to the Observer for Partners in Population and Development.

Mr. Alam (Partners in Population and Development): Partners in Population and Development (PPD), an intergovernmental alliance of 26 member countries, congratulates the General Assembly for adopting the Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030 (resolution 70/266, annex). The Declaration is a commitment to end the AIDS epidemic by 2030 and contribute to the achievement of Sustainable Development Goals. PPD joins member countries in their pledge to intensify efforts towards the goal of comprehensive prevention, treatment, care and support programmes that will help to significantly

reduce new infections, increase life expectancy and quality of life. It will also strive for the fulfilment of human rights and dignity of all people vulnerable to and made vulnerable by HIV and AIDS.

From all evidence, HIV/AIDS continues to pose a global emergency while being a serious threat to the development, progress and stability of communities and societies across the world. It requires an exceptional, coordinated and comprehensive global response that recognizes that the spread of HIV is often a cause and consequence of poverty and inequality. An effective HIV/AIDS response therefore becomes an inseparable component of the strategy aimed at the achievement of the 2030 Agenda for Sustainable Development (resolution 70/1).

Our past experience makes a compelling case for adopting a holistic and more integrated systemic approach to ensuring access to quality people-centred health care. That is embedded in the promotion of the right to the highest attainable standards of physical and mental health and well-being and universal access to sexual and reproductive health, and other reproductive rights, in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action.

PPD is a partner of the Secretary-General's new Global Strategy for Women's, Children's and Adolescents' Health, which continues to galvanize global efforts to significantly reduce the number of maternal, adolescent, newborn and under-5 child deaths. In support of the Global Strategy and to secure the commitment of member countries, PPD hosted an international interministerial conference in Dhaka in November 2015, entitled "Every Woman, Every Child, Every Adolescent: A South-to-South Perspective on Survive, Thrive and Transform".

PPD notes with deep concern the unacceptably low rates of testing and treatment coverage among children in developing countries, including the lack of technical support in the elimination of mother-to-child transmission of HIV. An equally grave concern is that AIDS-related deaths are the second leading cause of death in adolescents globally. Grave concern also exists globally given that women and girls are still the most affected by the epidemic and that their ability to protect themselves from HIV continues to be compromised.

PPD reiterates that official development assistance (ODA) support will continue to remain crucial in the fight

against AIDS and urges that ODA providers reaffirm their respective ODA commitments to achieving the target of 0.7 per cent of gross national income. We also underscore the importance of enhanced international cooperation, particularly South-South cooperation, to support Member States in achieving the target of ending the AIDS epidemic by 2030.

Beyond its many benefits, South-South cooperation is now fostering a spirit of solidarity among peoples and countries of the South, based on their shared experiences and objectives and guided by the principles of respect for national sovereignty, non-conditionality and mutual benefit. It is important to restate that South-South cooperation is a complement, not a substitute, to North-South cooperation. South-South cooperation is now a natural element of international cooperation, and its potential for contributing to fighting HIV and AIDS needs to be optimally harnessed.

As part of its commitment to promote South-South cooperation in the HIV/AIDS response, Partners in Population and Development, along with the Government of Bangladesh co-hosted the twelfth International Congress on AIDS in Asia and the Pacific. The outcome document, known as the Dhaka Declaration, is fully consistent with the Political Declaration adopted at this session. The Declaration calls upon national Governments to, first, scale up, accelerate and universalize antiretroviral treatment coverage and improve access to treatment for those in need; secondly, improve access to HIV medicines, treatment services and commodities delivery to people living with HIV/AIDS; thirdly, request the Joint United Nations Programme on HIV and AIDS to continue to support South-South cooperation for the HIV/AIDS response.

The Acting President: In accordance with paragraph 11 of resolution 70/228, I now give the floor to Ms. Rita Wahab, from MENA-Rosa in Lebanon.

Ms. Wahab (MENA-Rosa): As a Lebanese, allow me first to introduce my speech with a quote from our famous philosopher, Kahlil Gibran, who spent many years in New York:

"Beauty is eternity gazing at itself in a mirror. But you are eternity and you are the mirror."

I come from the Middle East and North Africa (MENA) region, and I am among the activists and people of the region living with HIV. MENA is a

region that is for the first time featured at the high-level meeting of the United Nations. We are proud to consider as an achievement that MENA has been brought this far and that the United Nations has called upon our States for accountability — to hold authorities accountable for making care and treatment available for all. We sure have come a long way, and here we are witnessing the first milestone in our successful journey towards defeating AIDS and openly referring to key populations.

As we all know, the right to health is a fundamental human right, which includes access to affordable, timely and quality health care services. The MENA region is the region with the least antiretroviral therapy coverage — only 17 per cent of people living with HIV are receiving treatment. Stigma and discrimination, gender inequality, punitive laws and legal barriers, along with certain cultural and social practices in MENA, are preventing women, adolescents and key populations, namely, men who have sex with men, transgenderer people, people living with HIV, injecting drug user, sex workers, prisoners, refugees and migrants and so forth, from seeking comprehensive and sustainable services and enjoying their rights. Those barriers and practices put key populations at great risk and lead to human rights violations.

Discrimination against women living with HIV, and particularly women from key populations, continues to be pervasive and to influence health behaviours, care-seeking, adherence to treatment and health outcomes. Stigma and prejudice represent leading obstacles to the enjoyment of sexual and reproductive health by women living with HIV in all their diversity.

The humanitarian crisis in MENA, at a time when we are witnessing the largest movement of refugees since the Second World War, is a core challenge that is increasing the vulnerability of women and key populations to HIV. We have rape, early marriage, trafficking, gender-based violence, prostitution, poverty, unemployment and so forth. Almost one third of the population of my own country, Lebanon, is made up of refugees from Syria and Iraq. More attention should be granted to host communities. We tend to neglect this issue. Unfortunately, political awareness and engagement are not always in our favour, which is clearly shown by the lack of services and domestic funding. In addition, MENA is not on donors' agenda.

However, in the midst of all that, there is a light we need to focus upon. The ministerial resolution endorsed by the Council of Arab Ministers of Health in Cairo in 2016 was developed in consultation with civil society organizations and people living with HIV. The acknowledgement by the League of Arab States concerning the role of civil society organizations as a major partner in implementing the Arab AIDS strategy was noteworthy.

Our presence is growing, as representatives can see. We are now more activists putting our heads together. We recently witnessed the emergence of thematic key populations networks thanks to the persistence of our activists and the supporting role of regional civil society organizations. To name just a few, we have MENA-Rosa as a voice for women living with HIV. We have the Middle East and North Africa Network of/for People who use Drugs for harm reduction. We have a forum for young people living with HIV in Y+. And we have the M-Coalition, a MENA coalition advocating for rights for men who have sex with men. Those networks have been supported by regional networks, such as Menara and Drana, and also by the support of the Regional Support Team for MENA of the Joint United Nations Programme on HIV/AIDS. We are now all aware that the concepts of greater involvement of people living with HIV/AIDS and meaningful involvement of people living with HIV and informed decision-making have started to become prevalent in the area.

The MENA requirements and needs include accessibility to friendly non-discriminatory sexual and reproductive services for key populations, women and adolescents; ensuring the confidentiality of beneficiaries with potential impacts on HIV prevention, access and the availability of quality comprehensive packages of care and treatment; safeguarding the dignity of people living with HIV; including healthy ageing in HIV and mental health programmes to ensure that women who struggle with mental health challenges receive the appropriate medication and support; and promoting a policy, legal and social environment to create safe environments for people living with HIV and key populations.

The President took the Chair.

Our key messages are that we must keep an ambitious agenda if we are to fast-track the response. We must push for more financing and resource mobilization, especially for programmes aimed at key populations in

our region. We must advocate for regional solidarity, including when it comes to humanitarian crises. We stress that health is a human right and the importance of integration within the Sustainable Development Goals agenda with an emphasis on gender equality and healthy youth. We must increase investment in innovative prevention programmes for young people, including comprehensive sexuality education. We call on the countries of our region to maintain their commitments to implement this strategy, which includes a human rights perspective.

I would like to conclude with this sentence: Since we are considered to be key populations, my humble suggestion is to use these keys to open the doors widely towards a new generation free from HIV and AIDS.

The President: In accordance with paragraph 11 of resolution 70/228, I now give the floor to Mr. Midnight Poonkasetwattana, Executive Director of the Asia-Pacific Coalition on Male Sexual Health.

Mr. Poonkasetwattana (Asia-Pacific Coalition on Male Sexual Health): What can I add from my corner of the world to this high-level meeting? I am Midnight Poonkasetwattana, Executive Director of the Asia-Pacific Coalition on Male Sexual Health (APCOM). My coalition works in the Asia-Pacific region, where a little over 60 per cent of the world's population lives.

If we want to fast-track the achievement of the 90-90-90 treatment targets by 2020, the time is now for urgent and increased investments in innovative regional and national approaches and programmes for, and led by, key populations in order to break down structural barriers that affect them and make them vulnerable to HIV, especially young gay men, men who have sex with men, and transgender people in our region.

That is my statement. I can hear many people thinking that this is nothing new and that they are all aware of the situation and what needs to happen to end HIV in our lifetime. Wonderful — but then my question is, Why do I and other key populations in this Hall have to repeat ourselves at every high-level meeting and other regional meetings to make the same plea?

As a proud gay man and member of the lesbian, gay, bisexual, transgender and intersex community, I echo the disappointment of civil society in the Asia-Pacific and other regions around the world with the 2016 Political Declaration (resolution 70/266, annex), which in our opinion, is not as strong as the 2011

Political Declaration. We are disappointed that the language with regard to key populations is not stronger in the Declaration, as it repeatedly omits, excludes and misrepresents the key populations of gay men and other men who have sex with men, sex workers, people who use drugs and transgender people as key populations affected by HIV worldwide. Not mentioning the most affected communities is to turn a blind eye to the realities in the world — and the reality of HIV/AIDS. By excluding those very people from the HIV response here in the Hall, the key populations programming is weakened.

The criminalization of and discrimination and stigmatization against gay men and other men who have sex with men increases vulnerability and creates barriers to accessing much-needed health services.

The Asia-Pacific region has more than 60 per cent of the world's population. It has the largest HIV epidemic outside of sub-Saharan Africa, and it is barely mentioned in the Declaration.

Asia has been experiencing a rapidly escalating epidemic among gay men and other men who have sex with men, and by 2020 is predicted to be home to nearly 50 per cent of new cases of HIV transmission, in particular among younger age groups. That was forecast in 2008 by the Commission on AIDS in Asia, and yet we see little political commitment. Let me give the Assembly some examples.

The prevalence among men who have sex with men is more than 5 per cent in countries like China, Indonesia, Malaysia, Myanmar, Thailand and Viet Nam. The prevalence rate is higher in cities, at 15 to 31 per cent in urban centres like Bangkok, Hanoi and Jakarta. Only about half of the men who have sex with men get tested for HIV. Access to condoms for low-income men who have sex with men is just 31 per cent, and just less than 50 per cent for high-income men who have sex with men. Ninety per cent of men who have sex with men in the Asia-Pacific region do not have access to HIV prevention and care because of discriminatory laws. Eighteen out of 38 countries in our region criminalize same-sex sexual behaviour. Spending on HIV prevention for men who have sex with in the region is less than 7 per cent of the total HIV budget. Moreover, at the global level, transgender women are 50 per cent more vulnerable to HIV.

Drastic financial assistance cuts represent another worrying trend in our region, as countries transition

out of international assistance. Even United Nations institutions that used to support APCOM have not been able to commit financial support for us this year. The trend does not look good and hurts the very people whom we are trying to help.

The fifth replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria is under way in a challenging environment to regain commitments from donor Governments, and transitioning countries are experiencing grave difficulties with domestic financing. The required and desired funding transition comes too quickly, too abruptly and without proper planning — and in fact is destroying the carefully built-up investments in HIV infrastructure and the gains in combatting the epidemic. Also, domestic financing comes with the threat that Governments will overlook and underresource responses for community system strengthening, key populations, policy advocacy and prevention services, which are currently mostly funded through international sources.

As we leave here today with the newly adopted 2016 Declaration, I hope that we can all utilize other opportunities to undertake more progressive action and commitments on the ground to ensure equitable access to quality and non-discriminatory prevention, treatment and care and support services led by, and for, key populations. I specifically hope that we can commit to naming key populations and young key populations, including gay men and other men who sex with men, sex workers, transgender people and injecting drug users; commit to a road map towards removing policies on HIV-related travel restrictions and deportation, and the criminalization of key populations and the lesbian, gay, bisexual, transgender and intersex community; commit to removing age restrictions and parental and marital consent requirements for adolescents and young people; commit to ensuring universal access to comprehensive harm reduction, sexual and reproductive health and rights, HIV information services and comprehensive sexuality education for all; commit to strengthening language on commitments to sustainable funding for civil society and meaningful community engagement; commit to optimizing the use of existing flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights, specifically geared towards promoting access to, and trade in, medicines; commit to using innovation and to bringing new technology to bridge and link prevention to treatment and care and support services, in particular on the use

of pre-exposure prophylaxes for men who have sex with men, community-based and -led HIV testing and HIV self-testing, for example, and commit to using social media and online technology for service delivery.

Last but not least, I request that Member States explore, develop and maintain effective partnerships led by key populations and serving community organizations. I believe that there should be strong commitments from Member States to engaging with communities as partners, leaders and beneficiaries, including the allocation of resources for community organizations and support for the role of community-led organizations in addition to service delivery — for example, in areas of policy and advocacy engagement, quality assurance and community mobilization.

We are, after all, Member States' assets and citizens — and we are here with them, and that shows our strong commitment to ending AIDS.

The President: In accordance with paragraph 11 of resolution 70/228, I now give the floor to Mr. Kieran Daly, Deputy Director of Global Policy and Advocacy of Bill and Melinda Gates Foundation.

Mr. Daly (Bill and Melinda Gates Foundation): We need to revolutionize the AIDS response in order to build on the recent gains in a way in which we can work in partnership within different sectors. Over the past 35 years, we have made tremendous advances in HIV that redefine what is possible in global health. The impressive progress that many have noted this week is testament to the commitment and hard work of so many people in this Hall and across the world.

When this deadly disease first emerged, it was impossible to imagine that today many people living with HIV would be able to lead such healthy, long lives or that we would have such novel ways to protect against infection. But it is clear that we are at a pivotal point. We cannot simply keep doing what has worked so far. To accelerate progress in new ways, we need to become better and become even faster and smarter in the way in which we do it. To get there, we first must overcome big challenges.

Significant gaps remain in our ability to comprehensively address the HIV/AIDS epidemic. First, for prevention, if we do not dramatically and urgently address the plateauing rate of decline in new infections, we risk erasing recent gains. Despite breakthroughs, such as the initial scale-up of voluntary

medical male circumcision and the introduction of oral pre-exposure prophylaxis in several countries, we are not applying sufficient resources to fully deploy these tools, including condoms, in the places where they will have the highest impact.

Secondly, for treatment, we have seen a tremendous increase in access to life-saving treatment and its prevention impact. And yet too few people are able to maintain treatment regimens to entirely suppress the virus. To continue to improve treatment outcomes for as many people as possible, it will be essential to tailor health-care delivery to the diverse needs of the people living with HIV, from self-testing to simplified care approaches.

Thirdly, for prevention, many people at the highest risk do not have access to tools and services that meet their unique needs, as representatives have just heard from the two previous speakers. Young women in sub-Saharan Africa in particular lack HIV-prevention options that can protect them and fit with the realities of their daily lives. Understanding and addressing the significant social and structural factors and barriers to accessing services by young women, sex workers, men who have sex with men, transgender people and people who use drugs is essential. This response has to be driven by access to, and the use of, better data that really directly addresses each of their unique circumstances and delivers what they and the data tells us works.

When Melinda Gates was here at the General Assembly in September 2015, she spoke about the importance of investing in the health of women and girls and emphasized that important point about data and measuring progress. The message here is that it is not just about collecting data, but the use of better data to inform smarter policy programming and accountability.

Moving forward, we need to continue to expand access to life-saving tools and services, but do it faster, smarter and, in some cases, differently. Beyond existing tools being used more effectively, therefore, we need dedicated investment now into new game-changing HIV-prevention tools. Ultimately, we need long-acting options that harness the power of the immune system, such as a vaccine or long-acting antibodies, and that needs to be factored into the cost of the epidemic.

Lastly, while we have seen and heard about impressive increases in many countries' commitment of funding to their own epidemics, this needs to be much

more widespread. Along with that, the Global Fund to Fight AIDS, Tuberculosis and Malaria needs to be fully funded to the \$13 billion that it is requesting, and the leadership of the United States President's Emergency Plan for AIDS Relief must be continued. That, along with country investments, can help to ensure that the world continues to unite, as the private sector and the public sector, with communities towards achieving an AIDS-free world.

The President: We will now hear brief presentations by one of the co-Chairs of each of the five panel discussions of the high-level meeting.

I first give the floor to the co-Chair of Panel Discussion 1, His Excellency Mr. Ratu Epeli Nailatikau.

Mr. Nailatikau (Fiji): It is my great pleasure to present the co-Chairs' summary of Panel Discussion 1, on the theme "AIDS within the Sustainable Development Goals: leveraging the end of AIDS for social transformation and sustainable development", which was held on 8 June from 11 a.m. to 1 p.m. I had the honour to co-chair the Panel with His Excellency Mr. Kwesi Amissah-Arthur, Vice-President of Ghana. The key messages emerging from this thematic Panel were as follows.

First, this high-level meeting demonstrates that the international community is committed to and serious about implementing the Sustainable Development Goals (SDGs), especially ending the AIDS epidemic by 2030. The Political Declaration (resolution 70/266, annex) we adopted commits us to a road map and ambitious targets for 2020, while highlighting that ending AIDS will both contribute to, and benefit from, progress across the 2030 Agenda for Sustainable Development (resolution 70/1). The strategy of the Joint United Nations Programme on HIV/AIDS for the period 2016-2021 was cited as an instrument to support countries in achieving the targets. It is now up to us to demonstrate the political will required to achieve them, underpinned by a commitment to action on human rights, equality, dignity and justice.

Secondly, fulfilling the SDG commitments to leaving no one behind demands removing barriers to the full realization of the rights of people living with, affected by and at risk of HIV, including entrenched structures of economic, social and legal exclusion, as well as marginalization, which includes criminal laws, harmful gender norms and discriminatory practices. There was discussion about how political considerations

at times prevented moving forward with evidence-based responses to HIV, such as access to comprehensive sexuality education and the decriminalization of sex work.

Thirdly, the Panel discussed how the AIDS response had paved the way for legal reforms and creating enabling environments. During the discussion, the Russian Federation, one of the 35 countries that still have HIV-related restrictions on the entry, stay and residence of foreign citizens living with HIV, informed the Panel about the lifting of some of those restrictions and about its commitment to continue efforts to lift the remaining restrictions in the nearest future.

Fourthly, the AIDS response has taught us that multisector and multi-stakeholder action works. It has demonstrated how health and development gains can be achieved only by working with a range of partners from public, private and civil society spheres to tackle social, economic and gender inequalities using rights-based approaches. Strong intersectoral collaboration can help address barriers that block access to services and that enhance social protection. The private sector has an important role to play in delivering goods and services, aside from supporting the AIDS response with innovation, technology and financing modalities.

Fifthly, fast-track targets focus on reaching specific populations and locations where HIV investment will have the greatest impact. In practice, that requires overcoming barriers that some populations, in particular key populations, are facing to access social services and protect themselves from HIV. While the AIDS response is about people, we clearly need strong data and comprehensive strategic information. Such data must be disaggregated and democratized to help communities effectively play their role as agents of change. Meaningful participation by affected communities in all aspects of the AIDS response, including monitoring and accountability, is critical to ensuring that it is relevant, evidence-informed, cost-effective and rights-based.

Sixthly, the 2016 Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030 (resolution 70/266, annex) sets out a road map of commitments to achieve the SDG target of ending the AIDS epidemic by 2030. Civil society has a critical role to play in reaching the SDG targets and the commitments of the Political Declaration through community service-delivery and

citizen-led accountability. That role can be fulfilled only with adequate funding and the fusion of community responses in national AIDS plans, as well as full community engagement in the political processes.

The Panel concluded by recognizing the urgency of, and the tremendous opportunity offered by, fast-tracking the response in order to reach the ambitious vision set out in the 2030 Agenda of an inclusive world with social justice for all.

The President: I now give the floor to the co-Chair of Panel Discussion 2, First Lady of Panama Lorena Castillo de Varela.

Ms. Castillo de Varela (Panama): It is my great pleasure to present the co-Chairs' summary of Panel Discussion 2, on the theme "Financing the end of AIDS: the window of opportunity", which was held on 9 June from 3 to 6 p.m. I had the honour to co-chair the Panel with His Excellency Mr. Roch Marc Christian Kaboré, President of Burkina Faso. The key messages emerging from the Panel were as follows.

The global commitment to ending AIDS as a public health threat by 2030 cannot be met without increased funding, more efficiency and improved programme effectiveness. Greater investment in the AIDS response needs to be front-loaded in the next five years to reach \$26.2 billion by 2020 in low- and middle-income countries. Governments and development partners must increase their investments to close the nearly \$7 billion gap between the resources available in 2014 for HIV and the 2020 peak to avoid a looming funding crisis. This additional investment will allow the world to meet the 2020 interim targets on the road to ending the AIDS epidemic as a global public health threat by 2030.

The AIDS response must invest existing and new funding wisely by rapidly scaling up treatment and prevention services with more efficient and effective programmes and services. It is not only where the money comes from that is important, but also where it is being spent.

The Panel discussed the rational use of existing resources and placed emphasis on how development partners and low- and middle-income countries can front-load resources to reach the ultimate goal, including innovative financing mechanisms. Countries that can pay should do so in order for the international community to support other countries that have the will but not the financial capacity.

Other critical factors for the sustainability of the response were highlighted, including local production of antiretroviral medications in Africa, improvement in the procurement of commodities through price negotiations and access and affordability to modern pharmaceuticals in all countries.

There was a strong call for a different approach to facilitating the transition of countries moving into higher income brackets, including supporting community-based programmes in the process. Community-based programmes often suffer the most during transition, as they are funded largely by international resources.

We also called for fully funding the needs of men who have sex with men, people who inject drugs, sex workers, transgender people and prisoners, particularly the young people among them, with a special focus on young women and adolescent girls and investing in communities and scaling up public-private partnerships.

The Panel stressed forcefully that the cost of inaction for individuals, communities, countries and regions was simply too high and that the world could not afford to miss this window of opportunity to make funding sustainable and reinvigorate the AIDS response over the next five years. Finally, as one of the panellists stated,

"This is not so hard. This is a matter of money — and just a little bit."

The President: I now give the floor to the co-Chair of Panel Discussion 3, His Excellency Mr. Barnabas Sibusiso Dlamini.

Mr. Dlamini (Swaziland): It is my pleasure to present the co-Chairs' summary of Panel 3, on the theme "Getting ahead of the looming treatment crisis: an action agenda for reaching 90-90-90", which was held on 9 June from 11 a.m. to 1 p.m. I had the honour to co-chair the Panel with His Excellency, Mr. Ruhakana Rugunda, Prime Minister of the Republic of Uganda. The key messages emerging from the Panel were as follows.

The Panel considered that, while reaching the 90-90-90 target was essential to ending the AIDS epidemic by 2030, the current level of HIV treatment coverage was not sufficient to prevent the large number of AIDS deaths that occur today or to keep the epidemic from rebounding in many countries. There must be a further massive scaling-up in the provision of antiretroviral therapy, and that needs to happen as fast as possible.

The front-loading of increased investment to scale-up and sustain uninterrupted access to treatment within the next five years is imperative to ending the AIDS epidemic. Low- and middle-income countries need to increase domestic funding in accordance with their fiscal capacity and proportional to their burden of disease. However, many countries cannot afford to fund the required scale-up solely from domestic sources; therefore, sustained support from the international community is imperative.

New sources of financing also need to be found, including innovative financing and from public-private partnerships. Universal health care offers an opportunity to finance HIV services for all.

To access high-quality medicines at the lowest cost, countries need to fully leverage their negotiating potential by pooling procurement, voluntary licensing mechanisms and/or use flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights. The industry needs to further explore options for tiered pricing and differentiated intellectual property strategies.

In many countries, the first "90" is the bottleneck for the rest of the care cascade. To close the testing gap, appropriate strategies for people living with HIV to learn their status need to be put in place, including focused services based on epidemiology. Self-testing and community-based testing must be scaled up. Further task-shifting, integration and decentralization of HIV treatment services are critically needed, including community-based service-delivery, differentiated models of treatment and care and innovative public-private partnerships.

Data and information should be used to guide decisions to invest in testing and treatment services in specific populations and for key populations. The United States Global AIDS Coordinator announced a new President's Emergency Plan for AIDS Relief investment fund for key populations.

Opportunities to use HIV services as an entry point for other health services must be maximized. There is an urgent need for innovation in developing new HIV drugs, regimens and formulations, including for newborns and children, as well as new business models for making state-of-the-art drugs available to low- and middle-income countries.

Countries that currently have low treatment coverage need to redouble their efforts with increased political commitment, sufficient resources and a focus on the population groups that are most affected.

The Panel concluded that ending the AIDS epidemic was ambitious, but within reach. The path to reaching the 90-90-90 target is clear, and we all have a critical role to play in it.

The President: I now give the floor to the co-Chair of Panel Discussion 4, His Excellency Mr. Alexis Nguema Obame.

Mr. Nguema Obame (Gabon) (spoke in French): It is my pleasure to present the co-Chairs' summary of the salient points of Panel Discussion 4, on the theme "Leaving no one behind: ending stigma and discrimination through social justice and inclusive societies", which was held on 9 June from 3 p.m. to 5.30 p.m. His Excellency Mr. Paul Biyoghe Mba, First Vice-Prime Minister of the Gabonese Republic, had the honour to co-chair this Panel with His Excellency Mr. Faustin Archange Touadera, President of Central African Republic. The key messages emerging from this thematic panel were as follows.

Many speakers recalled that the AIDS epidemic was more than a medical issue; it was one of human rights. The epidemic has revealed social and legal fractures and gaps between nations and within communities. In all countries, socially vulnerable and marginalized individuals and communities, including women, adolescent girls, prisoners, migrants, sex workers, men who have sex with men, transgender persons and people who use drugs, continue to bear the highest burden of the epidemic.

It was noted that AIDS had exacerbated levels of stigma, prejudice, discrimination and even violence towards those living with HIV or vulnerable to infection. Forced sterilization and coerced abortion of women living with HIV have been documented in at least 14 countries, which is a violation of their sexual and reproductive health and rights. People living with, and vulnerable to, HIV have demanded protection against stigma and discrimination and have called for justice, dignity, fairness and access to health services for all, including comprehensive harm-reduction services for people who use drugs.

Progress has been made in efforts to measure stigma and discrimination, including through the

People Living with HIV Stigma Index. Focused programmes are reducing stigma and discrimination in diverse settings, including health facilities, schools, workplaces and faith communities. Speakers shared important examples of how people living with, and vulnerable to, HIV had successfully advocated for legal and policy reforms, including the lifting of HIV-related restrictions on the entry, stay and residence for people living with HIV and ending the criminalization of HIV transmission.

While there had been some progress, the panellists and speakers expressed their serious concern about the slowness of the reforms and observed that much more remained to be done to address the exclusion and marginalization that prevented key populations from being able to benefit from the services available to put an end to AIDS.

We must increase investment in programmes to advance human rights and reduce stigma and discrimination, including through the key human rights programmes referred to in the 2011 Political Declaration (resolution 65/277, annex) and reiterated in the 2016 Political Declaration.

Data systems must include all affected populations, and Governments need to make full use of those data to inform programming and drive progress. Speakers emphasized that the 90-90-90 goals should be a first step towards ensuring that no one was left behind. Otherwise, 10 per cent of the population would continue to remain at the margins and the 2030 Sustainable Development Goals (resolution 70/1) would not be achieved.

The response to AIDS has inspired broader efforts aimed at combating structural inequalities and vulnerabilities, and as such serves as a pathfinder for more inclusive societies, as set forth in the 2030 Agenda. Speakers commended the ambitious plan set in the 2016-2021 strategy of the Joint United Nations Programme on HIV/AIDS. It provides a road map to end AIDS by 2030 by ensuring healthy lives for all, as set forth in Sustainable Development Goal (SDG) 3, while fully committing to the principles of equality enshrined in SDGs 5 and 10 and SDG 16, which are essential to leaving no one behind. Future success requires equal opportunities for women, including protection against discrimination and domestic violence.

Within those efforts, sustainable access to life-saving medicines will require addressing the intellectual property regimes that prevent millions

of people from gaining access to HIV, hepatitis, tuberculosis and other treatments. Several statements underscored that that must remain a priority social justice issue, so that intellectual property rights do not take precedence over public health and over the right of any persons living with HIV to have access to life-saving medicines.

Leaving no one behind is a human rights-imperative and a public-health necessity. Civil society advocacy and programmes require increased support and investment, and mechanisms such as the Robert Carr Fund play important roles in directing resources to civil society. The active participation of all stakeholders is essential to success and to creating ownership and effective, sustainable action. Faith communities and the private sector are vital partners.

Human rights efforts and programmes must be fast-tracked in order to overcome legal and other barriers that hinder efforts to reach everyone, wherever they are, with the services that they need. The world will not end the AIDS epidemic without efforts aimed at ending discrimination, challenging exclusion and advancing social justice.

The President: I now give the floor to the co-Chair of Panel Discussion 5, His Excellency Mr. Mothetjoa Metsing.

Mr. Mothetjoa Metsing (Lesotho): It is my great honour and privilege to present the co-Chairs' summary of Panel 5, on the theme "Children, adolescent girls and young women: preventing new HIV infections", which was held on 10 June from 10.00 a.m. to 1.00 p.m. I had the honour to co-chair the Panel with Her Excellency Ms. Ava Rossana Guevara Pinto, Vice-President of the Republic of Honduras. The key messages emerging from the Panel were as follows.

Many speakers acknowledged and commended the significant progress evidenced by new HIV infections having fallen by 35 per cent between 2000 and 2014 and the commitment to ensuring that no babies are born with HIV and that mothers are kept alive and well. However, panellists strongly emphasized that much more needed to be done to ensure that no one was left behind. All speakers reaffirmed the need for the HIV response to focus on reducing the disproportionate and heightened vulnerability of women and adolescent girls.

The discussions emphasized that there was no magic bullet. We need a combination of efforts to address

the sexual and health needs of adolescent girls and young women to effectively reduce their risk of HIV. That requires concrete and pragmatic interventions that are evidence-based and comprehensive and cover biomedical and structural interventions. The aspect of child-, early and forced marriage was mentioned by several speakers and participants from the floor. Examples of legislation making child marriage illegal were highlighted, as well as actions ensuring that girls were kept in school and communities were sensitized to harmful cultural practices, including "harmful masculinities".

Speakers further stressed the need for addressing harmful cultural norms through which older men engage with young women, thereby increasing young women's vulnerability to HIV and gender-based violence. That was emphasized as a global problem. It was also emphasized that the sexual and reproductive health and rights of women living with HIV needed to be fulfilled and protected, and no woman should be subjected to forced sterilization.

Speakers reaffirmed that there would be a challenge in dramatically reducing new HIV infections among young women and girls within the next five years. However, it was agreed that it would be possible if we invested in a holistic approach that combined social protection and economic empowerment, including the provision of cash transfers, scaling up school enrolment, addressing gender-based violence, scaling-up comprehensive sexuality education and ensuring sexual and reproductive health services for adolescent girls, young women and their partners, including for key populations.

Many speakers reiterated the following key areas for joint global action: developing coordinated and multilayered approaches that addressed adolescent girls and young women; funding, engaging and building on the knowledge of a strong and vibrant youth and women's platform, including young women living with HIV and adolescents and youth in all their diversity; involving local and national institutions to ensure the sustainability of programmes; targeting adolescents and young people, with a focus on girls and young women, whereby they have access to quality secondary education, including comprehensive sexuality education that addresses gender equality and gender-based violence; and scaling up comprehensive HIV and gender-based violence prevention programmes, including the provision of new technologies such

as pre-exposure and post-exposure prophylaxis. Services and health-promotion efforts that target the male partners of adolescent girls and young women, including testing and condom access, need to be scaled up. That will ease the burden of responsibility on adolescent girls and young women. We must invest in communities in which young women and adolescent girls are safe, empowered and protected from violence. Furthermore, men and boys need to be engaged in the promotion of gender equality and the prevention gender-based violence. Finally, programmes for prevention of mother-to-child transmission need to be fully funded.

Everybody on the panel concurred that we can dramatically reduce the number of new infections within the next five years. That reminded one participant of what an African slave once said:

"There is no rope long enough to bind people who refuse to submit, and sooner or later the rope has to be cut".

We also have to refuse to submit to this scourge, and sooner or later we will have to cut the vicious cycle of the disease.

The President: We have come to the end of three fully engaging days of discussion, and I thank the Chairs of the interactive panels for providing such thorough and concise summaries. Overall, we have heard about the great progress that has been made in the fight against HIV/AIDS, thanks to the concerted efforts of Governments, business, international partners, young people, women's groups, activists and everyday citizens living with HIV. We have heard about the pain, suffering and exclusion that millions of people living with HIV and their families experience, and that millions more are likely to experience, especially those in key populations, unless things change.

But we also heard about hope and possibility. We heard again and again that, together, we have the power, the resources, the knowledge and the technology to fast-track our HIV/AIDS response and to make ending the AIDS epidemic one of the first and one of many amazing successes of the era of the Sustainable Development Goal (resolution 70/1).

The question now, however, is whether we have the will and the humanity to make that happen or not. The strong statements of intent by many Member States and others these past few days suggest that we do, as indeed does the forward-looking Political Declaration unanimously supported two days ago (resolution 70/266, annex). I commend all delegations for their understanding in reaching consensus and for their commitment to raising the level of ambition.

I would also like to reiterate my congratulations to the facilitators of the successful negotiations, namely, Ms. Mwaba Patricia Kasese-Bota, Permanent Representative of Zambia; Mr. Jürg Lauber, Permanent Representative of Switzerland; and their teams. On behalf of the General Assembly, I thank all of them very much indeed. Lastly, I wish again to thank Mr. Michel Sidibé and the entire team of the Joint United Nations Programme on HIV/AIDS; and all within the United Nations and beyond who helped ensure that this high-level meeting was a success.

In conclusion, this epidemic has haunted the lives of millions and denied them their human dignity for far too long. The time for that to change is now, and the opportunity to do so has never been greater. Let us therefore get to it. I thank participants for their participation in this important meeting. I wish everyone a good further journey.

The meeting rose at 5.55 p.m.